Background

The California Office of the Patient Advocate (OPA) is charged with representing the interests of health plan members and OPA has the mandated responsibility to publicly report on health care quality. OPA published its first Health Care Quality Report Card in 2001 and has since successfully updated and enhanced the Report Card every year. The current version (2013 Edition) of the online Health Care Quality Report Card is at: www.opa.ca.gov.

Performance reports are reported for 209 physician organizations that participate in the Integrated Healthcare Association (IHA) Pay for Performance initiative (P4P) (see details on this initiative at: http://www.iha.org/pay_performance.html). IHA is a statewide multi-stakeholder leadership group that promotes quality improvement, accountability and affordability of health care. IHA collects quality data on the physician organizations that contract with commercial HMOs for P4P and provides the data to OPA for the Health Care Quality Report Card. The IHA physician organizations are referred to as medical groups in the Report Card and in the remainder of this document.

The 2013 Edition of the Report Card is published in March 2013, using data reported by medical groups in Reporting Year (RY) 2012 for performance in Measurement Year (MY) 2011. The data source is IHA's Pay for Performance measures. IHA develops and maintains the P4P measure set; many measures are based on HEDIS measures. NCQA develops and maintains the HEDIS performance measures as the national standard set of health plan clinical process and outcomes measures and many of these measures are adapted for measurement at the medical group level.

Scoring Methodology

There are three levels of measurement:

1. **Category**: Medical Group Provides Recommended Care is the aggregated All-Clinical summary performance score composed of seventeen (17) HEDIS or similar to HEDIS commercial measures.

2. **Topic**: There are six condition topic areas composed of groupings of seventeen (17) clinical measures.

3. **Clinical Measures**: There are twenty-one (21) clinical measures reported by IHA. Most, but not all, are HEDIS measures. Four of these are stand alone clinical measures.

See Appendix A for mapping of clinical measures to Topics and Categories.

Performance grading

Medical groups are graded on performance relative to other medical groups for "Medical Group Provides Recommended Care." All of the performance results are expressed such that a higher score means better performance. Seventeen clinical measures are aggregated to create the All-Clinical summary performance score: "Medical Group Provides Recommended Care". Based on relative performance, groups are assigned star ratings for multi-level composites (category and topics).

For the 2013 Edition report card, RY 2011 (MY 2010) values from medical groups statewide are used to set performance cutpoints for the clinical measures.

1. **Composite Calculation for Category and Topic Scoring**

   Seventeen (17) measures are aggregated to create the summary performance score. The summary scoring process is a two-step method:

   a) **In Step 1,** calculate topic level composite: Measures are organized into each of 6 condition topics. A mean score is calculated for each topic by summing the proportional rates for each measure within the topic and dividing by the number of measures. With the exception of outlier results which are excluded from the dataset, the scores for all reporting groups are used to calculate topic and summary scores. Valid results for non-reporting groups are included.

   The medical group must have reportable results for at least half of the eligible measures for a given topic to score that topic. To calculate condition topic scores, for any medical group that has missing data for one or more measures within a given condition topic, an adjusted half-scale rule is applied to adjust for the missing values – this rule is described below. The condition topic measures are equally weighted when combining them and calculating a condition topic score.

b) **In Step 2,** calculate the category level composite: Calculate the mean of the 6 condition topic means. Each of the 6 condition topic means is equally weighted based on the number of measures that comprise a topic.

The medical group must have reportable results for at least half of the measures to be eligible for the summary performance score.

A medical group's overall summary performance score is rounded to the tenths decimal and the performance grade is assigned per the cutpoints and the buffer zone adjustment factor (see pg. 6).

2. **Individual Measure Scoring**

a) The individual measure scores are calculated as proportional rates using the numerators and denominators that are reported per the P4P measurement requirements. Measures will be dropped if at least 50% of medical groups cannot report a valid rate.

b) The measure results are converted to a score using the following formula:

(Measure numerator/Measure denominator)*100

3. **Handling Missing Data**

a) Not all medical groups are able to report valid rates for all measures. In order to calculate category and topic star ratings for as many medical groups as possible, we impute missing data under specific conditions using an adjusted half-scale rule. This is accomplished by developing an actual measure level imputed result for plans with missing data, and using those results for star calculations. Imputed results are not reported as an individual rate. If a plan is able to report valid rates for at least half of its measures in a topic, then missing values will be replaced using an adjusted half-scale rule for all measures in the topic. Because eligibility for missing value re-assignment (imputation) is assessed independently at the topic and category levels, it is possible to have a category score even if measure or topic scores are missing.

b) For topic and category star rating level, a missing value is NOT applicable for medical groups. All the medical groups are assigned stars for all levels.

4. **Outliers**

Controlling Blood Pressure for Diabetes Patients is the single measure for which an outlier rule is used. Scores below 35% are designated as an extreme outlier and are excluded from the scoring given the premise that the scores represent deficient information systems and not true performance. This measure is not reportable for 101 medical groups due to its outlier status. Groups with scores of zero (0) are labeled as "Not willing to report" and scores of 0.1-34.9 are labeled as "No report due to incomplete data."

5. **Changes from 2012 Edition Report Card to 2013 Edition Report Card and Notes**

    a) The Optimal Diabetes Care-Combo 1 measure used by P4P will be included in the reportable measures set; it is labeled "Successfully Controlling Diabetes" on the report card.
    b) The Breast Cancer Screening measure has been updated to include the 52-69 age population.
    c) Three measures are reported as stand alone measures and are not included in the 6 condition topic scores or in the overall summary performance score: 1) Low Back Pain Care, 2) Antibiotic Treatment for Acute Bronchitis 3) Monitoring for Persistent Medications and 4) Successfully Controlling Diabetes.
    d) The performance thresholds were updated. Cutpoints for calculating the stars are now based on one year-prior data; for the 2013 Edition report card, the cutpoints are based on the RY 2011 scores for all reporting medical groups.

6. **Calculate Percentiles**

    a) One of four grades is assigned to each of the 6 condition topics and to the "Medical Group Provides Recommended Care" category using the cutpoints shown in Table 1. Cutpoints were calculated per the RY2011 results for all medical groups. The cutpoints are calculated by summing the statewide scores for the respective percentile value for each measure in a given topic. In turn, the measure-specific percentile scores are summed and an average score is calculated for each of the 3 cutpoints for that topic.

    b) The topic cutpoints for Treating Children, Diabetes Care and Asthma Care have been adjusted for RY 2012 given the measure changes for each of these topics. In turn, the All Clinical summary performance cutpoints are revised to reflect changes to the cutpoints for these three underlying topics.

7. **From percentiles to stars**

    a) Medical group performance in MY 2011 is graded against score thresholds derived from MY 2010 data. There are three thresholds corresponding to 4 star rating assignments. If a topic or category composite rate meets or exceeds the "Excellent" thresholds, the medical group is assigned a rating of four stars. If a topic or category composite rate meets or exceeds the "Good" threshold (but is less than the "Excellent" threshold) then the medical group is given a rating of three stars. If a topic or category composite rate meets or exceeds the "Fair" threshold (but is less than the "Good" threshold) then the medical group is given a rating of two stars. Topic or category scores that are less than the two star "Fair" threshold result in a rating of one star "Poor".

b) The grade spans vary for each of the 6 condition topics listed in Table 1:

Top cutpoint: 90th percentile California reporting medical groups

Middle cutpoint: 50th percentile California reporting medical groups

Low cutpoint: 25th percentile California reporting medical groups

Table 1: Medical Group Clinical Performance Cutpoints RY 2011, 2013 Edition report card

Condition Topics	Number of Measures Included	Excellent Cutpoint	Good Cutpoint	Fair Cutpoint	Poor* Cutpoint
Checking for Cancer	3	78	56	48	<48
Chlamydia Screening	1	69	53	45	<45
Treating Children	4	86	68	47	<47
Asthma Care	1	77	68	62	<62
Diabetes Care	6	83	72	62	<62
Heart Care	2	86	78	70	<70
All HEDIS Summary Performance- Medical Group Provides Recommended Care	17	82	67	56	<56

*Scores below the Fair cutpoint are graded "Poor"

Special scoring is used for the Children's Physician Medical Group – an all-pediatric group. This group reports 5 measures: asthma, Chlamydia screening, child immunizations, children with upper respiratory infection and children with pharyngitis. The group's summary indicator is comprised of these 5 measures. Correspondingly, the performance cutpoints for the group are based on these 5 measures and the RY 2012 cutpoints are 80, 62, and 46 for the 90th, 50th and 25th percentiles respectively.

8. **Buffer Zones**

A buffer zone of a half-point (0.5) span is applied. Any medical group whose score is in the buffer zone that is 0.5 point below the grade cutpoint is assigned the next highest category

grade. For example, for "Medical Group Provides Recommended Care" using a cutpoint of 79, a group whose score is 78.5 would be graded "excellent." A score of 78.4, which is outside of the buffer zone, would be assigned a grade of "good."

9. **Legends to Explain Missing Scores**

Three categories are used to explain instances in which a medical group measure is not reported:

No Report Due to Incomplete Data.

a) Medical group's score is not reported because the score is ruled an outlier given its extreme difference from the all-medical groups' mean score. For RY 2012, the outlier rule applies to a single measure: Controlling Blood Pressure for Diabetes Patients. Groups with scores of zero (0) are labeled as "Not willing to report" -2 and scores of 0.1-34.9 are labeled as "No report due to incomplete data" on the OPA website.

b) Medical group's score is not reported if the group's encounter rate does not meet the IHA threshold encounter rate. The P4P clinical measures rely on an encounter rate threshold to ensure that health plans have the minimal level of data completeness for medical groups. This is reported as "No report due to incomplete data" on the OPA website.

Too Few Patients to Report.

a) Medical group score is not reported because the measure's denominator has fewer than 30 patients. This is reported as "Too few patients to report" on the OPA website.

Not Willing to Report.

a) Medical group declined to report its results. This is reported as "Not willing to report" on the OPA website.

Appendix A. Topics and Weights

Topic	Measure	Weight
Stand Alone Measure Only	Checking Patients on Long Term Medications (MPM)	N/A
Stand Alone Measure Only	Successfully Controlling Diabetes (CDC)	N/A
Stand Alone Measure Only	Testing for Cause of Back Pain (LBP)	N/A
Stand Alone Measure Only	Treating Bronchitis with Antibiotics (AAB)	N/A
Asthma Care	Medications for People with Asthma (AMROV)	1
Checking for Cancer	Cervical Cancer Screening (Appropriately Screened Women) (ECSASOV)	3
	Breast Cancer Screening (BCS52)	
	Colorectal Cancer Screening (COL)	
Chlamydia	Chlamydia Screening in Women (CHLAMSCR)	1
Diabetes Care	HbA1c Testing (HBASCR)	6
	HbA1c Control (<8.0%) (HBAC8)	
	LDL Screening (LDLSCR)	
	LDL Control <100 (LDL100)	
	Nephropathy Monitoring (NEPHSCR)	
	Blood Pressure Control for Diabetes Patients<140/90 (CBPD4)	
Heart Care	LDL Screening for Patients with Cardiovascular Conditions (CMCSCR)	2
	LDL Control <100 for Patients with Cardiovascular Conditions (CMC100)	
Treating Children	Childhood Immunization (CISCOMBO)	4
	Adolescent Immunizations (IMACOMBO)	
	Appropriate Testing for Children with Pharyngitis (CWP)	
	Appropriate Treatment for Children with Upper Respiratory Infection (URI)	